Senate File 368 - Introduced

SENATE FILE 368
BY MATHIS and RAGAN

A BILL FOR

An Act relating to Medicaid managed care improvements, and including effective date provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

BENEFITS COVERED UNDER HEALTH AND WELLNESS PLAN

Section 1. Section 249A.3, subsection 1, paragraph v, subparagraph (2), Code 2017, is amended to read as follows:

(2) Notwithstanding any provision to the contrary, individuals eligible for medical assistance under this paragraph "v" shall receive coverage for benefits pursuant to 42 U.S.C. §1396u-7(b)(1)(B); adjusted as necessary to provide the essential health benefits as required pursuant to section 1302 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148; adjusted to provide prescription drugs and dental services consistent with the medical assistance state plan benefits package for individuals otherwise eligible under this subsection; and adjusted to provide habilitation services consistent with the state medical assistance program section 1915(i) waiver. Beginning July 1, 2017, coverage for benefits shall also include coverage for integrated health home services, residential substance abuse treatment, assertive community treatment, nonemergency medical transportation, and peer support.

Sec. 2. DIRECTIVE TO DEPARTMENT OF HUMAN SERVICES. Upon enactment of this division of this Act, the department of human services shall request federal approval of an amendment to the medical assistance state plan, as necessary, to implement this division of this Act effective July 1, 2017.

Sec. 3. EFFECTIVE UPON ENACTMENT AND CONTINGENT IMPLEMENTATION. This division of this Act, being deemed of immediate importance, takes effect upon enactment. However, the department of human services shall implement this division, effective July 1, 2017, contingent upon receipt of federal approval of the state plan amendment request submitted under this division of this Act. The director of human services shall notify the Code editor of the receipt of approval and the date of implementation.

DIVISION II

MEDICAID MANAGED CARE QUALITY IMPROVEMENT

Sec. 4. MEDICAID MANAGED CARE CHANGES. The department of human services shall adopt rules pursuant to chapter 17A and shall amend any Medicaid managed care contract effective July 1, 2017, to provide for all of the following:

1. PRIMARY CARE PROVIDERS

a. A Medicaid managed care organization shall include as a primary care provider any provider designated by the state as a primary care provider, subject to a provider's respective state certification standards, including but not limited to all of the following:

(1) A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.

(2) An advanced registered nurse practitioner.

(3) A physician assistant.

(4) A chiropractor.

b. A Medicaid managed care organization shall not impose more restrictive scope-of-practice requirements or standards of practice on a primary care provider than those prescribed by state law as a prerequisite for participation in the managed care organization's provider network.

2. CASE MANAGEMENT

a. A Medicaid managed care organization shall provide the option to the case manager for a Medicaid member, if the case manager is not otherwise a participating provider in the member's managed care organization provider network, to enter into a single case agreement to continue to provide case management services to the Medicaid member at the member's request.

b. A Medicaid managed care organization shall allow peer support specialists to serve as case managers for members receiving behavioral health services, and shall not require that such peer support specialists hold a bachelor's degree from an accredited school, college, or university.

3. MEMBER STATUS CHANGES

a. A Medicaid managed care organization shall provide prior notice to a provider of a member of any change in the status of the member that affects such provider at least fourteen days prior to the effective date of the change in status. If notification is not received by the provider and the member continues to receive services from the provider, the Medicaid managed care organization shall reimburse the provider for services rendered.

b. If a member transfers from one managed care organization to another, the managed care organization from which the member is transferring shall forward the member's records to the managed care organization assuming the member's coverage at least thirty days prior to the managed care organization assuming such coverage.

c. If a provider provides services to a member for which the member is eligible while awaiting any necessary authorization, and the authorization is subsequently approved, the provider shall be reimbursed at the contracted rate for any services provided prior to receipt of the authorization.

4. UNIFORMITY OF PROGRAM

a. The department of human services shall work with the Medicaid managed care organizations to institute consistency and uniformity across processes and procedures, including but not limited to those related to claims filing and denial of claims, integrated health home criteria, and appeals and grievances.

b. The department shall require the use and application of the following definition of medically necessary services across all Medicaid managed care organizations:

"Medically necessary services" means those services that a prudent health care provider would provide to prevent, diagnose, or treat an illness, injury, disease, or symptoms of an illness, injury, or disease in a manner that meets all of the following requirements:

(1) The services are in accordance with generally accepted

standards of medical practice.

(2) The services are clinically appropriate in terms of type, frequency, extent, site, and duration.

(3) The services are not primarily for the economic benefit of the managed care organization or health care provider or for the convenience of the member or health care provider.

5. OVERSIGHT. The department shall require completion of an initial external quality review of the Medicaid managed care program by January 1, 2018. Additionally, the department shall contract with the university of Iowa public policy center to perform an evaluation of the program by January 1, 2018.

6. DATA. The department shall amend the requirements for quarterly reports to require that managed care organizations report not only the percentage of medical and pharmacy clean claims paid or denied within a certain time frame but also all of the following:

a. The total number of original medical and pharmacy claims submitted to the managed care organization during the time period.

b. The total number of original medical and pharmacy claims deemed rejected and the reason for rejection.

c. The total number of original medical and pharmacy claims deemed suspended, the reason for suspension, and the number of days from suspension to submission for processing.

d. The total number of original medical and pharmacy claims initially deemed either rejected or suspended that are subsequently deemed clean claims and paid, and the average number of days from initial submission to payment of the clean claim.

e. The total number of medical and pharmacy claims that are outstanding for thirty, sixty, ninety, one hundred eighty, or more than one hundred eighty days, and the total amount attributable to these outstanding claims if paid as submitted.

f. The total amount requested as payment for all original medical or pharmacy claims versus the total actual amount paid

as clean claims and the total amount of payment denied.

7. REIMBURSEMENT. For the fiscal year beginning July 1, 2017, Medicaid providers or services shall be reimbursed as follows:

a. For fee-for-service claims, reimbursement shall be calculated based on the methodology in effect on June 30, 2017, for the respective provider or service.

b. For claims subject to a managed care contract:

(1) Reimbursement shall be based on the methodology established by the managed care contract. However, any reimbursement established under such contract shall not be lower than the rate floor established by the department of human services as the managed care organization provider or service reimbursement rate floor for the respective provider or service in effect on April 1, 2016.

(2) For any provider or service to which a reimbursement increase is applicable for the fiscal year under state law, upon the effective date of the reimbursement increase, the department of human services shall modify the rate floor in effect on April 1, 2016, to reflect the increase specified. Any reimbursement established under the managed care contract shall not be lower than the rate floor as modified by the department of human services to reflect the provider rate increase specified.

(3) Any reimbursement established between the managed care organization and the provider shall be in effect for at least twelve months from the date established, unless the reimbursement is increased. A reimbursement rate that is negotiated and established above the rate floor shall not be decreased from that amount for at least twelve months from the date established.

8. PRIOR AUTHORIZATION

a. A Medicaid managed care organization shall approve or deny a prior authorization request submitted by a provider for a prescription drug or service within the following periods,

as applicable:

(1) For urgent claims, within a period not to exceed forty-eight hours from the time the Medicaid managed care organization receives the request.

(2) For nonurgent claims, within a period not to exceed five calendar days from the time the Medicaid managed care organization receives the request.

b. Emergency claims for prescription drugs or services shall not require prior authorization by a Medicaid managed care organization. Prior authorization shall not be required for prehospital transportation and emergency services, and coverage shall be provided for emergency services necessary to screen and stabilize a member. A provider that submits written certification to the managed care organization within seventy-two hours of admission of a member who was admitted to a hospital through the emergency department shall create a presumption that the emergency services were medically necessary for purposes of coverage.

c. If a Medicaid managed care organization approves a provider's prior authorization request for a prescription drug or service for a patient who is in stable condition as verified by the provider, the prior authorization shall be valid for a period of twelve months from the date the approval is received by the provider.

d. If a Medicaid managed care organization approves a provider's prior authorization request for a prescription drug or service, the managed care organization shall not retroactively revoke, limit, condition, or restrict the prior authorization after the prescription drug is dispensed or the service is provided.

e. Any change by a Medicaid managed care organization in a requirement for prior authorization for a prescription drug or service shall be preceded by the provision of sixty days' prior notice published on the managed care organization's internet site and to all affected providers before the effective date

of the change.

f. Each managed care organization shall post to the managed care organization's internet site prior authorization data including but not limited to statistics on approvals and denials of prior authorization requests by physician specialty, medication, test, procedure, or service, the indication offered, and if denied, the reason for denial.

g. The department of human services shall require any Medicaid managed care organization under contract with the state to jointly develop and utilize the same prior authorization review process, including but not limited to shared electronic and paper forms, subject to final review and approval by the department.

Sec. 5. EFFECTIVE UPON ENACTMENT. This division of this Act, being deemed of immediate importance, takes effect upon enactment.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to the Medicaid program and Medicaid managed care.

Division I of the bill amends the required benefits under the Iowa health and wellness plan to provide that, beginning July 1, 2017, covered benefits shall include integrated health home services, residential substance abuse treatment, assertive community treatment, nonemergency medical transportation, and peer support. The bill directs the department of human services (DHS), upon enactment of the bill, to request federal approval of an amendment to the medical assistance state plan, as necessary, to implement the provision. The division takes effect upon enactment, but is not to be implemented until DHS receives federal approval of the state plan amendment request.

Division II of the bill includes provisions relating to Medicaid managed care quality improvement.

The bill requires DHS to adopt rules and amend Medicaid

managed care contracts as necessary to implement the improvements.

The bill requires Medicaid managed care organizations (MCOs) to include as a primary care provider any provider designated by the state as a primary care provider, subject to a provider's respective state certification standards, including but not limited to a physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist; an advanced registered nurse practitioner; a physician assistant; and a chiropractor. The MCO is prohibited from imposing more restrictive scope-of-practice requirements or standards of practice on a primary care provider than those prescribed by state law as a prerequisite for participation in the managed care organization's provider network.

With regard to case management services, the bill requires MCOs to provide the option to the case manager of a Medicaid member, if the case manager is not otherwise a participating provider of the member's managed care organization provider network, to enter into a single case agreement to continue to provide case management services to the Medicaid member at the member's request. The bill also requires MCOs to allow peer support specialists to serve as case managers for members receiving behavioral health services, and shall not require that such peer support specialists hold a bachelor's degree from an accredited school, college, or university.

With regard to member status changes, the bill requires MCOs to provide prior notice to a provider of a member of any change in the status of the member that affects such provider at least 14 days prior to the effective date of the change in status. If notification is not received by the provider and the member continues to receive services from the provider, the MCO shall reimburse the provider for services rendered. If a member transfers from one MCO to another, the MCO from which the member is transferring shall forward the member's records to the MCO assuming the member's coverage at least 30

days prior to the MCO assuming such coverage. Additionally, if a provider provides services to a member for which the member is eligible while the provider is awaiting any necessary authorization to provide the service, and the authorization is subsequently approved, the provider shall be reimbursed at the contracted rate for any services provided prior to receipt of the authorization.

With regard to uniformity of the program, DHS is required to work with the MCOs to institute consistency and uniformity across processes and procedures, including but not limited to those related to claims filing and denial of claims, integrated health home criteria, and appeals and grievances. DHS is required to use and apply the definition of "medically necessary services" included in the bill across all Medicaid MCOs.

With regard to oversight, the bill requires DHS to complete an initial external quality review of the Medicaid managed care program by January 1, 2018, and to contract with the university of Iowa public policy center to perform an evaluation of the program by January 1, 2018.

With regard to data, the bill requires DHS to amend the requirements for quarterly reports to require that MCOs, in addition to reporting the percentage of medical and pharmacy clean claims paid or denied within a certain time frame, to also report additional data regarding claims as specified in the bill.

With regard to reimbursement, the bill requires reimbursement beginning July 1, 2017, for Medicaid providers and services to be calculated based on the methodology in effect on June 30, 2017, for the respective provider or service for fee-for-service claims and for claims subject to a managed care contract reimbursement shall be based on the methodology established by the managed care contract. However, any reimbursement established under such contract shall not be lower than the rate floor established by DHS as a rate

floor for the respective provider or service in effect on April 1, 2016. However, if any provider or service to which a reimbursement increase is applicable for the fiscal year under state law beginning July 1, 2017, upon the effective date of the reimbursement increase, DHS shall modify the rate floor in effect on April 1, 2016, to reflect the increase specified. Any reimbursement established under the managed care contract shall not be lower than the rate floor as modified by DHS to reflect the provider rate increase specified. Any reimbursement established between the managed care organization and the provider shall be in effect for at least 12 months from the date established, unless the reimbursement is increased. A reimbursement rate negotiated and established above the rate floor shall not be decreased from that negotiated amount for at least a 12-month period.

With regard to prior authorization, the bill provides that approval from the MCO shall be received by the provider submitting the prior authorization request for a prescription drug or service within a period not to exceed 48 hours from the time the MCO receives the request for urgent claims and within a period not to exceed five calendar days for nonurgent claims; prohibits an MCO from requiring prior authorization for emergency claims for prescription drugs or services and prohibits prior authorization for certain emergency services; provides that once approval is received by a provider for a prior authorization request for a prescription drug or service for a patient who is in stable condition as verified by the provider, the approved prior authorization shall be valid for a period of 12 months; prohibits retroactive action once a prior authorization is approved; requires that any change by an MCO in a requirement for prior authorization for a prescription drug or service shall be preceded by 60 days' prior notice published on the MCO's internet site and provided to all affected providers before the effective date of the change. The bill requires an MCO to place certain prior authorization

data on the MCO's internet site and requires DHS to require any Medicaid MCO under contract with the state to jointly develop and utilize the same prior authorization review process, including but not limited to shared electronic and paper forms, subject to final review and approval by DHS.

Division II of the bill takes effect upon enactment.